

Creating a Culture *of* Change

ACCOUNTABLE CARE COLLABORATIVE :: 2014 ANNUAL REPORT



COLORADO
Department of Health Care
Policy & Financing



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ACC Year in Review

It's hard to believe it's been only three years since the launch of the Accountable Care Collaborative (ACC) program in 2011. The Department started the program with fewer than 50,000 clients enrolled, and at the end of FY2013–14, there were more than 600,000 clients in the program. Though the ACC has grown and evolved, its goals remain the same: to improve the overall health of our clients while lowering costs.

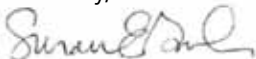
With the ACC, Colorado has created a different model, a new way of delivering health care that will yield results over the long term. We are not just implementing a program; we are growing and shaping an ecosystem. All of the pieces—Regional Care Collaborative Organizations, our Statewide Data Analytics Contractor, primary care medical home providers, clients and their communities—are interdependent. The system depends on collaboration and integration of medical, mental health and social services at the local level. By partnering with communities across the state, we're driving innovation that has staying power along with accountability, responsibility, and ownership at the local level. As in an ecosystem, small changes in one area can make a big difference to the system. The ACC's innovations are an investment not only in Medicaid but also in the health and wellbeing of the whole state.

The ACC's growth and success started with a solid foundation that has been carefully and deliberately laid over the last three years. Colorado has taken a thoughtful, step-wise approach to building the ACC, testing new approaches to health care delivery and payment. We learn from what doesn't work and build on what works to make it better. This foundation gives us a firm footing to explore new ways to improve health and health care in Colorado.

As we look toward the future of the ACC, we're planning to move toward greater integration of physical and behavioral health, more sophistication in using health information technology and health data, and further progress in paying for value. These strategies advance our goals of better health for our clients, better financial health for our state, and a better experience of care for clients and providers.

The ACC will continue to test big ideas in health care through manageable, incremental steps with our partners and communities. I look forward to the future with great anticipation and optimism.

Sincerely,



Susan E. Birch, MBA, BSN, RN
Executive Director



*Susan E. Birch, Executive Director
Department of Health Care Policy and Financing*



About the Accountable Care Collaborative

When the Accountable Care Collaborative (ACC) launched in 2011, the Department's goal was not to simply deliver health care, but to improve the health of Medicaid clients. Many factors contribute to health: personal health behaviors, access to medical care, good provider-patient communication, a connected health system and access to resources to meet basic needs.

The ACC is designed to make incremental change on all of these fronts. It provides all the usual benefits of Medicaid with added supports to ensure that members get the right care at the right time in the right place. The ACC also takes wellness and non-medical needs into consideration, helping members overcome obstacles that have little to do with health care but everything to do with overall health.

This report looks at the progress made during the last year in each of the fundamental elements of the ACC: developing strong regional networks, connecting members to care and supporting providers. It also describes how the ACC is innovating with data and payment models to drive change in each of these areas. Details about data and payment innovations are included in each section of the report.

The Accountable Care Collaborative

The primary goals of the ACC are to:

- ▶ Improve member health
- ▶ Improve the member and provider experience
- ▶ Contain costs

The ACC fosters integration and collaboration across the spectrum of health care. It connects and supports providers to make collaboration possible, using the following framework:

1. Regional Care Collaborative Organizations (RCCOs)

Seven organizations throughout the state that develop a network of providers; support providers with coaching and information; manage and coordinate member care; connect members with non-medical services; and report on costs, utilization and outcomes for their population of members.

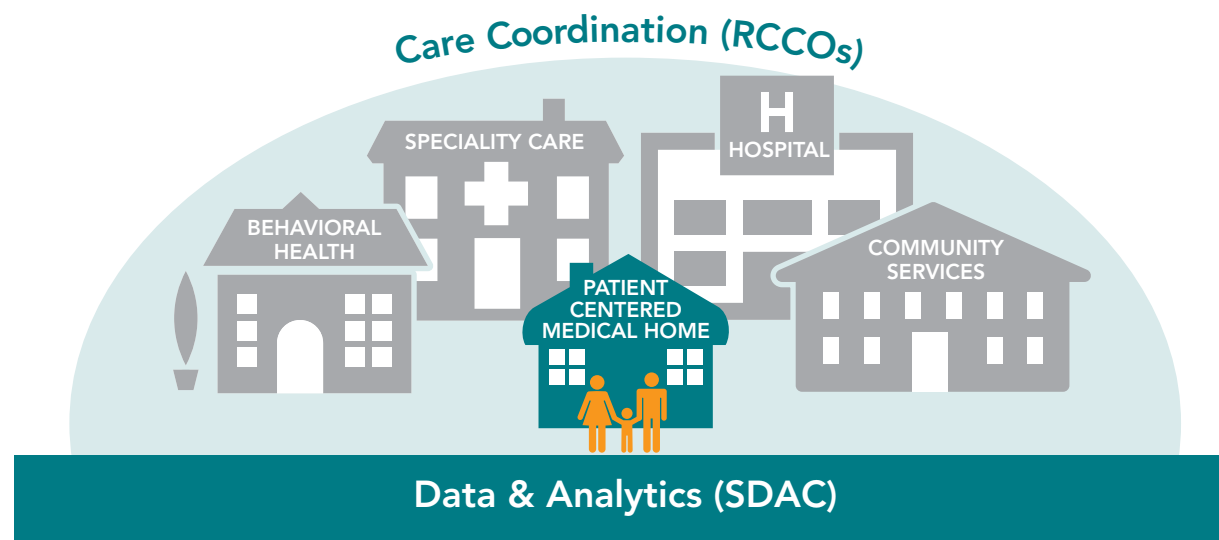
2. Primary Care Medical Providers (PCMPs)

Primary care providers contracted with a RCCO to serve as medical homes for ACC members.

3. Statewide Data and Analytics Contractor (SDAC)

A health information technology contractor that analyzes and reports on claims data to help the Department, RCCOs and PCMPs see patterns in how members are using health care services.

HOW THE ACC WORKS



Regional Care Collaborative Organizations develop a network in a member's community. The network allows them to coordinate care and connect members to community resources. The Statewide Data and Analytics Contractor supports the system by supplying RCCOs and providers with data to inform their decision-making.



Using Data in New Ways

Accountability is central to the ACC. The ACC is using existing data to learn about the needs of its population, how health care services are used, and how the ACC can improve health outcomes and contain costs. The Statewide Data and Analytics Contractor (SDAC) uses claims data to answer these questions.

Data is used for “hot-spotting”—finding geographic areas that have a higher utilization of certain services or a population with more complex medical needs. It is also used to identify individual members who have had many medical needs in the past, and need care coordination assistance and self-management coaching.

The ACC also uses data to track RCCO and PCMP performance on Key Performance Indicators (KPIs), proxies for appropriate utilization of services. The following are the KPIs that were used this year:

1. Emergency Room Visits.

Fewer emergency room visits are a good sign that the ACC is addressing problems before they become emergencies, and diverting members from the emergency room for routine care. This will continue to be a KPI in the coming year.

2. 30-Day All-Cause Hospital Readmissions.

Fewer readmissions for the same condition means that members are getting the right care when they leave the hospital, so they do not have to go back within 30 days. This will not be a KPI in the coming year; instead, the Department will create a measure to assess the quality and adequacy of post-discharge care.

3. High-Cost Imaging.

High-cost imaging is overused throughout the American health care system. Fewer CT scans and MRIs mean lower costs, less exposure to radiation for members, and a reduced chance of “finding” problems that do not require treatment. Performance on this measure has been so strong that it will not be a KPI in the coming year, but will continue to be tracked to maintain the gains already made.

4. Well-Child Visits.

This measure asks PCMPs to do an annual well-child check for every child younger than age 18. This KPI will continue in the coming year, but will focus on children aged 3–9.

Another KPI planned for the coming year is Post-Partum Care. This will help providers address any physical or mental health challenges for ACC members who recently had a baby, giving both mother and baby a good start.

This year’s KPI results are on page 16. For most populations and indicators, the utilization increased during the first six months of enrollment and then decreased when clients were in the program for more than six months. This mirrors nationwide utilization trends for populations gaining new or better access to health care.

Paying for Value

Payment is a powerful way to set into motion changes to the health care system. The ACC uses a hybrid of several payment strategies to shift the health care system from its current focus on delivering a high volume of services to getting the most value possible.

The program's strategy is incremental, using fee-for-service payments as a base and gradually adding more payment strategies that reward providers for the wise use of services and good health outcomes. This incremental strategy is intentional, a way to gradually strengthen and build Colorado's health care infrastructure to adjust to a new way of thinking about care.

The ACC pays for value by tying payment to its mission, goals and key strategies:

▶ Key Performance Indicators

RCCOs and PCMPs receive payments for reaching KPI targets. The Department is also looking at tying payments to targets that are not Key Performance Indicators but are important to the ACC's success, such as getting the right care for members after they leave the hospital and screening for physical and behavioral health and wellness in adolescents.

▶ Enhanced medical home standards

PCMPs, that meet five of the nine high standards for an enhanced patient-centered medical home. The RCCOs chose to set aside money from their own per-member-per-month payments to create this incentive.

▶ More members with a medical home

In the coming year, RCCOs will receive a full per-member-per-month payment only for members who are attributed to a medical home within six months of enrolling in the ACC.

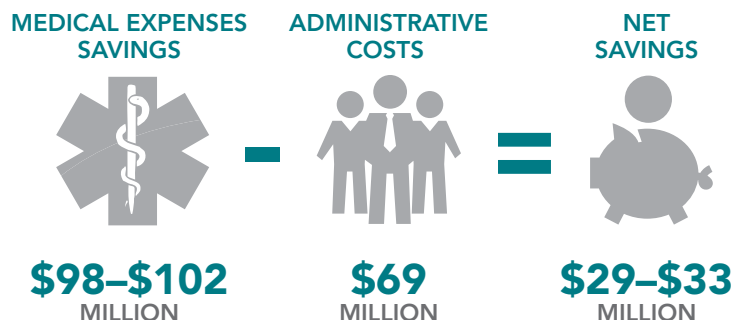


"When providers have access to data, members don't have to keep retelling their stories. We know where they have been, so we can focus on getting them where they need to go."

– Donna Mills,
Integrated Community Health Partners (RCCO 4)

The ACC as a whole generated savings that exceeded its administrative costs this year.

The ACC achieved gross savings in medical costs between \$98 million and \$102 million with net savings totaling \$29 million to \$33 million after administrative expenses.



Using Data

The SDAC prepares data that helps RCCOs and PCMPs understand which services are used most frequently and which are needed most in the region.

Paying for Value

Incentive Payments: Regions that meet or exceed targets on Key Performance Indicators receive incentive payments. This encourages RCCOs and PCMPs to engage partners to meet their goals.



Developing a Regional Strategy

The ACC is built on strong regional networks of both medical and social services. Colorado's regions and communities are unique in geography, demographics and priorities. The ACC is designed to leverage regional strengths to create local networks to meet unique community needs.

This regional model was designed to build from existing centers of excellence throughout the state. While all RCCOs do the same basic functions, their focus and expertise differ depending on the needs and resources in their region. There are too many successes and areas of expertise to highlight in this brief report, so we have included just one example of how each RCCO is developing excellence. The map on the following page shows the regions, along with the areas of excellence we are highlighting in this report.

Building Relationships Between Providers

The role of convener is an important one for RCCOs. When RCCOs build connections among providers, they make better use of community resources to improve the health of members. PCMPs are the only providers that formally contract with a RCCO, but the RCCOs are building relationships and connections with all provider types in their region.

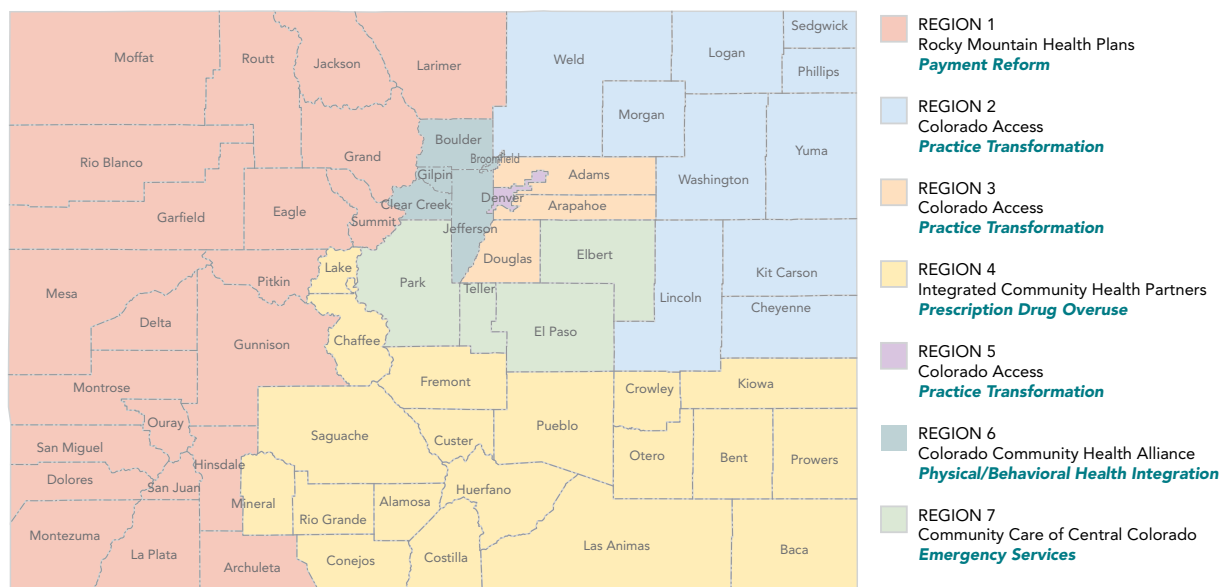
In RCCO 4 (serving south-central and southeast Colorado), Integrated Community Health Partners is bringing providers together to address the use and misuse of prescription drugs in the region. To address the problem, care coordinators are working directly with members who have filled many prescriptions for narcotics. But the problem

is system-wide and has many other potential solutions. RCCO 4 held a forum, “Opioid Use, Abuse, Misuse in Our Communities,” to bring together community leaders and medical providers to talk about the issue. This work is aligned with statewide work on preventing opioid abuse in Colorado. The connections forged among health care providers, substance use counselors and social service organizations have created a solid foundation for continued progress.

Moving Toward Integration

Full integration of all health services—medical, behavioral and dental—is the long-term vision of the ACC. RCCOs throughout the state are moving toward this goal with incremental changes like referral systems, care coordination and strategic partnerships.

In RCCO 6 (serving Boulder, Broomfield, Clear Creek, Gilpin and Jefferson counties), Colorado Community Health Alliance is working with its PCMPs across a spectrum of strategies for integrating behavioral health and medical services. Some practices in the region are at the beginning stages of the continuum; they are improving the referral process with timely referrals to behavioral health services and a communication feedback loop with the PCMP. Others are using telehealth video conferencing to link to behavioral health providers from PCMP sites. Some practices have had behavioral health services on site for a long time, or are now ready to bring a behavioral health professional on site. And two locations—one in Jefferson County and one in Boulder County—have a fully integrated physical-behavioral health clinic.



“There is no one-size-fits-all approach to integrating physical and behavioral health services. Each PCMP has unique needs and different levels of readiness for integration. Each one is at a different point on the continuum.”

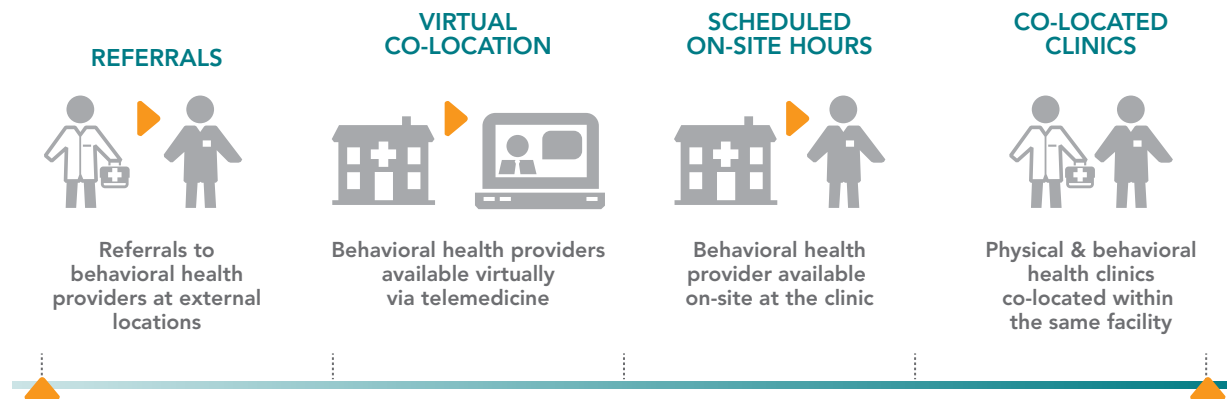


*— Adam Bean,
Colorado Community Health Alliance (RCCO 6)*



CONTINUUM OF PHYSICAL-BEHAVIORAL HEALTH INTEGRATION

This continuum represents different ways to bring physical and behavioral health closer together, from an efficient referral process with a feedback loop, to full co-location of physical and behavioral health services.



Using Data

The SDAC uses claims data to track medical expenditures for ACC members.

Paying for Value

Shared Savings: In the coming year, RCCOs and PCMPs will receive a share of the savings when the ACC saves on medical expenditures.

There are lessons to learn and share at every point on the continuum. Every point represents better connection between the services that meet the needs of a member as a whole person.

Connecting with Community Services

Person-centered care starts with understanding that a member is more than a patient. RCCO members need more than medical care to be healthy, so the RCCOs support, build on, and coordinate with existing services in their communities.

Many of the RCCOs collaborate with other service providers in their communities by maintaining an active referral system. In RCCO 4 (serving south-central and southeast Colorado), Integrated

Community Health Partners shares information with community partners through a web-based system. This system allows care coordinators and other social service providers to identify and work with members who have complex needs.

RCCOs also collaborate with communities to solve specific problems. In RCCO 7 (serving Park, Teller, El Paso and Elbert counties), Community Care of Central Colorado is working with first responders to prevent overuse of emergency services, especially ambulance transportation, while encouraging members to make good choices for their health. See the following story for more information on this collaboration.

“This is a community effort in response to a community-wide need. Our community wants emergency service resources to be used for true emergencies, and the right help to go to those who have health needs best served in other ways.”

– Kelley Vivian, Community Care of Central Colorado

Community Partnerships Make Life-Saving Connections

The RCCO in region 7, Community Care of Central Colorado, is partnering with the Colorado Springs Fire Department (CSFD) and its CARES program to prevent the overuse of emergency services. CARES is a partnership between CSFD, local hospitals and the RCCO to respond differently to community members who rely on the overburdened emergency response system for non-emergency or potentially preventable health needs. CARES helps RCCO members like Christy, who relied on emergency services for help better found elsewhere.

Christy had an alcohol problem that made it difficult to function. She made 56 emergency calls to 911 in one year, including 10 calls in the month of June. There was the structural fire that started when she was under the influence of alcohol and fell asleep with food on the stove, and another fire that began when she had fallen asleep while smoking. During the same time, she was admitted to the hospital six times for physical problems related to alcohol abuse.

Some of Christy's 911 calls were true emergencies, and some were not. But all were preventable.

CARES staff knew that it was unsustainable to have Christy continue to use emergency services in this way. They worked with the RCCO to find her the help she really needed. It is part of a partnership between CARES and the Region 7



Christy, center, with members of the CARES team.

RCCO to find solutions to the overuse of emergency services.

“This is a community effort in response to a community-wide need,” said Kelley Vivian of Community Care of Central Colorado. “Our community wants emergency service resources to be used for true emergencies, and the right help to go to those who have health needs best served in other ways.”

CARES worked with the RCCO to make arrangements for intensive outpatient therapy and a move to a sober living home. The relationship between CARES and the RCCO works because CARES interacts with members that the RCCO may never have seen, while the RCCO has access to a network of service providers.

Christy is now thriving, attending Alcoholics Anonymous meetings, therapy appointments and doctor appointments. She has a job to pay for her rent at the sober living home, and recently celebrated 60 days of sobriety with members of the CARES team there to share the milestone.

“I would have died,” said Christy, “had CARES not been there to help when I had given up on myself.”



Connecting Members to Care

The ACC's care delivery model works when all members have a medical home. For members with particularly complex health needs, a care coordinator supports the medical home to help these members get the right services.

When the ACC launched, the first priority was to connect members to a medical home—a focal point of care. Ready access to consistent, high-quality primary care is a basic foundation from which the ACC can grow to add and integrate services.

As of June 2014, there were 609,051 members enrolled in the ACC. This is approximately 58 percent of all Colorado Medicaid clients—a 74 percent increase in membership since June 2013. Approximately 70 percent are connected to a medical home. With this accomplishment, the ACC is ready to take the next steps towards integrated care, while continuing to emphasize the importance of a medical home through strategies like incentive payments and efficient enrollment processes.

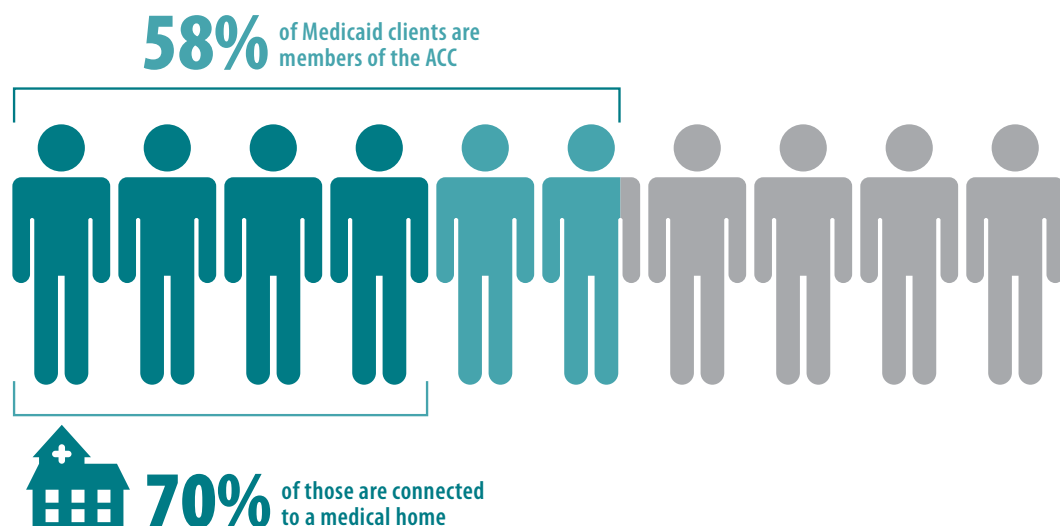
In the coming year, the ACC will expand its membership to include clients covered by both Medicare and Medicaid, in the ACC: *Medicare-Medicaid Program*. A medical home and care coordination are essential for this population, which often has complex health needs and is covered by two different systems (Medicare and Medicaid). RCCOs will be able to help these members learn self-management so they can take care of their chronic conditions. RCCOs will also help them with care transitions between hospital, rehabilitation hospital, nursing facility and back to home and community.

“In a year when we nearly doubled enrollment, the ACC is demonstrating that it can keep people well with primary care, reduce the demand for emergency services and save money in the long run.”



— Laurel Karabatsos, Deputy Medicaid Director

2013 PERCENT OF MEDICAID CLIENTS ENROLLED IN ACC



Using Data

The SDAC uses a claims data history to connect new ACC members to a PCMP. They look at which provider the member has seen most often in the past, and most recently.

Paying for Value

Incentive Payments: PCMPs receive an incentive payment for meeting five out of nine standards for a patient-centered medical home. This encourages PCMPs to make improvements like adopting electronic health records, using evidence-based guidelines and providing patient education to support self-management.



Supporting Providers

RCCOs support providers so providers can focus on delivering the best care. RCCOs help providers navigate the disparate parts of a fragmented health care system while simultaneously working to make the system more cohesive.

Helping Practices Grow and Change

One way the RCCO supports providers is by helping them adapt to changes in health care and make their practices work better for patients and providers alike. Practices often believe strongly in the ideal of being patient-focused but are working with old processes and systems that make it difficult to put members at the center. *Practice transformation* is the term used

to describe the shift toward new ways of organizing care to make it more patient-centered. Although “transformation” makes it seem magical and immediate, the reality is that practice transformation is a long journey taken one step at a time.

In RCCO 2 (serving northeast Colorado), 3 (serving Adams, Arapahoe and Douglas counties), and 5 (serving Denver County), Colorado Access meets its practices where they are, offering different kinds of assistance in response to the type and size of the practice, the population it serves, the practice’s unique challenges and the type of support requested.

Like most people, providers do best with transformation when they make small changes—and occasional big leaps—that add up to transformation.

Supporting Providers with Data

It can be a powerful learning experience when RCCOs help their PCMPs understand and interpret the claims data compiled by the SDAC. For example, practices may see for the first time how many (or how few) imaging services they use compared to other practices. Practices see the patterns and approach the issues with initiative and curiosity.

But it can be challenging to sift through data to find these patterns and the lessons they hold. Providers in regions 2, 3 and 5 rely on the RCCO, Colorado Access, to create usable and meaningful reports. “Thank you for helping us understand the data,” one provider said.

“We work with practices to meet them where they are and help them take the next step. We transform one step at a time.”



*– April Abrahamson,
Colorado Access (RCCOs 2, 3 and 5)*

Care Teams Improve Health Care Experience and Outcomes

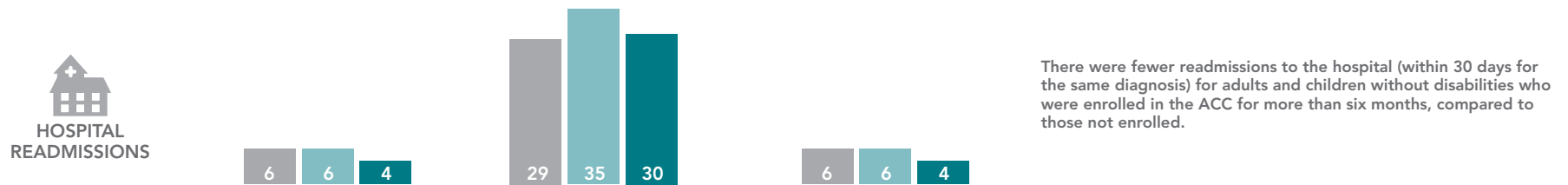
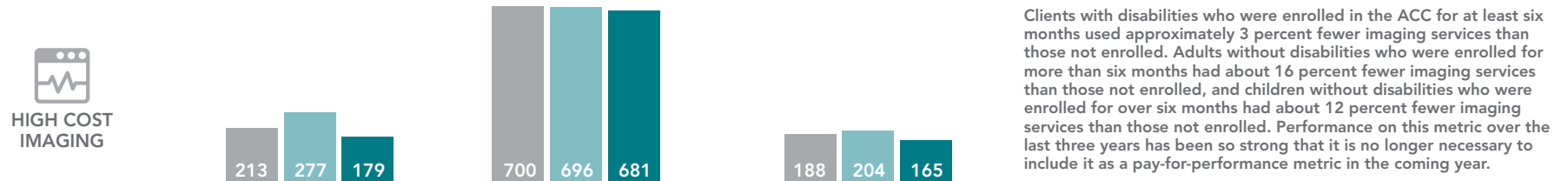
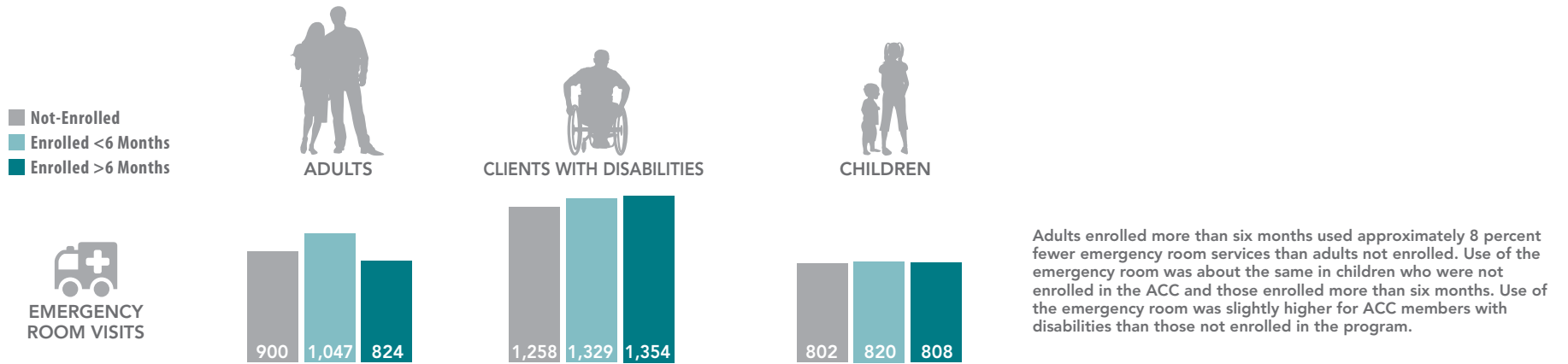
One provider understood the value of the RCCO in a new way when he was treating a member whose service dog had recently died. Circumstances like these are often challenging for providers because they affect the health of the member but lie just outside a provider’s responsibility and influence.

The service dog helped the patient manage his multiple conditions, including schizophrenia and anxiety. Management of these conditions is crucial for patients if they are to avoid emergency care. The provider noticed that the member’s symptoms were getting worse after the loss of his dog. When the provider told the care manager, the three met together and the care manager worked with the member to find a new service dog.

The member, provider and care manager all recognized the value of working together as a team, especially for members with complex needs. The care experience and outcomes are better when the team shares the responsibility.

2014 KEY PERFORMANCE INDICATOR RESULTS

Per 1,000 Members Per Year



50% of all children under age 18 enrolled in the ACC had at least one well-child visit this year.

“The data gives us a starting point so we know what questions to ask. Members don’t always understand the services they’ve received well enough to describe them to me. With data, we already have that information.”

– Kristi Meyer, Integrated Community Health Partners



Data Personalizes Care

It is not often that the words “data” and “person-centered” are found in the same sentence. But that is exactly what Kristi Meyer, a care coordinator with Integrated Community Health Partners in RCCO 4, says is data’s biggest benefit.

Kristi recalls one member identified by the data as someone who might benefit from care coordination. It was the first step in peeling back the layers of the health challenges for a member and his family.

One of the care coordinators on Kristi’s team, Tammy Moruzzi, contacted the member to help him manage his health conditions, including a chronic infectious disease and behavioral health care needs. Tammy learned that, in addition to his own health problems, the member was trying to help his son manage celiac disease and the nutritional challenges that come with it—on a low income.

“The data gives us a starting point so we know what questions to ask,” Kristi says. “Members don’t always understand the services they’ve received well enough to describe them to us. With data, we already have that information. The member and the care coordinator are starting from the same place so they can work together on next steps.”

Data and information do not magically solve problems or tell care coordinators what to do. Kristi is quick to point out that members do not change their health behaviors because we have data to show there is a problem. But the data helps her team identify patterns, problems and opportunities, so they can be full partners in a member’s care and build relationships that lead to lasting change and better health.

“Colorado Medicaid is leading the nation by effectively implementing a patient-centered care coordination model. The Accountable Care Collaborative facilitates partnerships and local innovation between primary and specialty care providers and other social service providers.”

*– John L. Bender, MD, FAAFP/Diplomate,
American Board of Family Medicine/ President,
Colorado Medical Society*



The Future of the ACC

The Department looks forward to another year of growth for the ACC, with new opportunities to strengthen Colorado's health care infrastructure as well as improve health outcomes and contain costs. The ACC plans to implement these new program strategies to support its goals in the coming year:

New Populations

Medicaid expansion makes it more important than ever to deliver high quality care efficiently so as to control costs. The ACC will grow to include more of the people covered by Medicaid, becoming the primary model of care delivery for those not participating in a waiver program. The Department will continue to innovate and build on the ACC's success in improving care and controlling costs.

Starting in September 2014, clients covered by both Medicare and Medicaid are eligible to participate in the ACC. These clients will be a part of the ACC: *Medicare-Medicaid Program*, which will coordinate their physical, behavioral and social health needs, and reduce duplication of services.

The addition of this new population is a result of a demonstration grant from the Centers for Medicare and Medicaid Services to better align Medicare and Medicaid for people covered by both. The ACC will partner closely with this demonstration program, as well as with Long-Term Services and Supports, to create a person-centered approach to health care and long-term care for these members.

Progress in Paying for Value

In the coming year, the ACC will take new steps toward paying for value instead of volume. Payment for reaching targets on Key Performance Indicators will continue along with new payments for additional important targets, such as getting the right care for members after they leave the hospital and screening for physical and behavioral health and wellness in adolescents.

There will also be increased payment for PCMPs that meet five out of the nine standards for an enhanced patient-centered medical home, and a payment strategy designed to increase the number of ACC members connected to a medical home within six months of enrolling. Additionally, the Department will continue to explore possible models for sharing the program's savings with RCCOs and PCMPs.

In FY 2014–15, the ACC is launching a payment

reform pilot program that has been in the planning stages during the last year. RCCO 1, Rocky Mountain Health Plans (serving Western Colorado) is testing a full-risk capitation model with a subset of its members. Instead of receiving both per-member-per-month payments and fee-for-service payments, Rocky Mountain Health Plans will receive one payment for all care delivered to those members. The payment amounts will differ depending on the age and eligibility type of the member.

Also, Rocky Mountain Health Plans has included additional payments to PCMPs that employ behavioral health providers as part of their comprehensive care teams. The ACC will use this pilot program to learn more about how to use payment strategies to better integrate care throughout the state.

From Medical Homes to Medical Neighborhoods

With a solid foundation of primary care through medical homes, the ACC is ready to develop its infrastructure to create medical neighborhoods. A medical neighborhood is a tightly connected yet flexible local system with seamless transitions between primary care, specialist care, hospital care, and self-management at home. It is care coordination at its most sophisticated, and makes the health care system more cohesive and less fragmented.

These networks will be particularly beneficial for Medicaid members who have a history of using a high number of services, like emergency room services, hospital stays, and high utilization of prescription drugs. RCCO 4 (focusing on Pueblo County) and

“As part of the ACC, this pilot program focuses on accountable communities rather than individual organizations, health equity for vulnerable populations, data-sharing to improve population health and, of course, value over volume. The difference is the payment model: it’s a shared savings opportunity at the community level that allows for the delivery of whole-person care.”



– Patrick Gordon,
Rocky Mountain Health Plans (RCCO 1)

RCCO 7 (focusing on El Paso County) are piloting new strategies to meet the needs of these members, using tools like motivational interviewing and the Patient Activation Measure (PAM).

Moving Towards Wellness

In the coming year, RCCOs across the state will work more closely with public health departments to help members and communities embrace wellness and create a built environment that promotes health. They will also look for ways to support hospitals in responding to the community needs that emerged in their Community Health Needs Assessments. These assessments, required of community nonprofit hospitals by the Affordable Care Act, identify unmet health needs in the community. Finally, RCCOs will collaborate on projects that give communities better access to healthy foods and increase opportunities for physical activity.

The Accountable Care Collaborative demonstrates good value while honoring Colorado's values: the opportunity for all Coloradans to lead healthy lives so we can make Colorado the healthiest state in the nation.



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